# EL PASO CARDIOLOGY ASSOCIATES, P.A.

## PATIENT REGISTRATION FORM

### PATIENT

LAST NAME _____ FIRST NAME _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK PHONE: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____ SEX: MALE ☐ FEMALE ☐

EMPLOYER'S NAME: _____ EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRED BY: _____ IS VISIT INJURY RELATED? YES ☐ NO ☐

DATE OF INJURY: _____ WORKER'S COMPENSATION? YES ☐ NO ☐ AUTO ACCIDENT? YES ☐ NO ☐

### INSURANCE INFORMATION

RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

*IF OTHER THAN SELF:*

NAME OF INSURED: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____ SEX: MALE ☐ FEMALE ☐

EMPLOYER'S NAME: _____ EMPLOYER'S ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____

### PRIMARY INSURANCE

PRIMARY INSURANCE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ INSURED IDENTIFICATION NUMBER: _____

GROUP NAME OR NUMBER: _____ POLICY HOLDERS NAME: _____

RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

### SECONDARY INSURANCE

SECONDARY INSURANCE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ INSURED IDENTIFICATION NUMBER: _____

GROUP NAME OR NUMBER: _____ POLICY HOLDERS NAME: _____

RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

### PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO THE PHYSICIAN WHO ACCEPTS ASSIGNMENT.

SIGNED: _____ DATE: _____

### PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PROVIDER (PHYSICIAN) FOR INSURANCE CLAIMS.

SIGNED: _____ DATE: _____

### PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING REFERRALS OR OTHER AUTHORIZATION REQUIRED BY MY INSURANCE COMPANY . IF I FAIL TO PROVIDE AUTHORIZATION/ REFERRAL, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.

SIGNED: _____ DATE: _____